TEMPLE HEALTH

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The Honorable Ron Wyden
Chairman
Committee on Finance

The Honorable Mike Crapo
Ranking Member
Committee on Finance

Sent Electronically to mentalhealthcare@finance.senate.gov

RE: Recommendations for Behavioral Health Enhancement

Dear Chairman Wyden and Ranking member Crapo,

I commend you for engaging stakeholders across the healthcare continuum to help Congress better understand how to address the challenges our nation's citizens face in accessing effective and timely treatment for mental health and substance use disorders. On behalf of Temple University Hospital, our patients, and the communities we serve, thank you for the opportunity to provide our insights on this important issue.

On the following pages, we offer ideas and suggestions on ways to enhance behavioral health care and treatment for substance use disorder. Initially, however, I provide relevant background on Temple University Hospital and its Episcopal Campus, where we offer many of these vital services.

I. About Temple University Hospital

Temple University Hospital is an indispensable provider of health care in the largest city in America without a public hospital. We embrace our essential role as the leading healthcare provider in one of our nation's most underserved communities. 86% of our inpatient admissions are for those covered by government programs; 45% by Medicaid and 41% by Medicare. In our immediate neighborhoods, 45% of residents live below the federal poverty level; 62% received a high school education or less; 23% are unemployed.

More than half of Temple University Hospital's patients are diagnosed with a behavioral health condition, and about 25% have a substance use disorder. In our service area, over 20% of residents report poor mental health, yet it is understood that only about half of people with a mental health condition receive the treatment they need.

Temple University Hospital's Episcopal Campus (Episcopal) was founded in 1852 as Episcopal Hospital to serve destitute members of its community. Today, Episcopal serves a diverse population comprised largely of lower socioeconomic African American and Hispanic patients.

Episcopal contains all of Temple University Health System's behavioral health services, including a 118-bed Behavioral Health Center, a psychiatric Crisis Response Center, a full-service Emergency Department and a 21-bed medical-surgical unit. Each year, Episcopal handles about 45,000 Emergency Department visits, 2,600 inpatient discharges and 12,000 Crisis Response Center visits. Our Crisis Response Center is one of the busiest on the East Coast.

Our behavioral health program is a recovery oriented treatment program offering hope for adults whose lives have been affected by a mental illness or co-occurring disorders. Many of our psychiatric patients have a diagnosis of one or more substance disorders. Over 30% of our patients have both a substance use disorder and other behavioral health issues; over 30% are homeless; and over 85% are unemployed. Last year our Crisis Response Center provided 2,400 warm handoffs and 17,000 mental health evaluations and coordinated support services.

While we address our community's behavioral health needs, we are on the front line addressing Philadelphia's opioid epidemic. In partnership with the Commonwealth, we are leading our region's *Pennsylvania Coordinated Medication-Assisted Treatment (PacMAT)* program by expanding treatment for opioid use disorder, creating vital partnerships with community-based sites. Through our *Housing Smart Program*, a collaboration with managed care payers and community partners, we provide housing to homeless individuals with opioid use disorder.

Central to our PacMAT program is our *Temple Recovery Using Scientific Treatment (TRUST)* Clinic, which coordinates services across emergency departments, health centers, physician offices and social service organizations. Integrated into our family medicine and internal medicine practice, TRUST provides low-barrier substance use disorder treatment with on-site peer recovery support and case management services to facilitate pathways to recovery.

Complementing this is our *Begin the Turn* street side mobile multidisciplinary unit. Staffed by a behavioral health professional, case manager, medical practitioner and social workers, this outreach team provides pharmacologic treatment for opioid use disorder and acute care services with a bridge to primary care and social services.

Separate from our clinical programs, we are a partner in two innovative housing programs located directly on Episcopal' s hospital campus. The *Beacon House Opioid Respite Center* is a collaboration with the City of Philadelphia, HACE community development corporation and Prevention Point. This 60-bed shelter offers critical services for those suffering from homelessness and substance use disorder. Meanwhile, *Project Home*, in partnership with the Philadelphia Housing Authority and the Commonwealth, is developing a 54-unit long-term recovery residence to serve those who are homeless, at risk of homelessness or recovering from a substance use disorder.

II. Recommendations for Enhancing Behavioral Healthcare

A. Ensuring Parity in Behavioral Health Care

We believe that ideal behavioral health care models reinforce all efforts to reduce stigma, eliminate barriers to access and are integrated with primary care. In terms of clinical effectiveness and cost savings, the value added of finding a medical home with a "one stop shopping experience" for diagnosis and treatment cannot be overstated.

To achieve this, however, **providers need fair and adequate reimbursement** for both inpatient and outpatient behavioral health services. In general, current rates are not sufficient to allow providers to compete for professional talent, to capitalize on innovation such as patient centered assessment technology or to consider expansion of needed services. Consequently, healthcare organizations struggle to recruit a very limited number of qualified providers and are often compelled to question the business case for continuing behavioral health services.

To ensure access to care for all, **consumers need affordable, comprehensive coverage that offers mental health and substance use disorder benefits on par with physical health benefits.** Thus we support the expansion of mental parity laws and limiting the availability of plans that do not cover mental health and substance use conditions such as short-term, limited duration plans.

Moreover, **payment rates across all payers, including those contracted with state Medicaid agencies to manage care for beneficiaries, should be actuarially sound to ensure that plans can adequately cover patient needs**. This will help eliminate the current disincentive for providers to offer mental health services, and further ensure that vulnerable populations are not disadvantaged in access to quality mental health care and treatment for substance use disorder.

To further ensure parity, **Congress should work with the payer, provider and consumer communities to ensure that criteria for medical necessity are no more stringent than for other types of covered services**. This is particularly important for Medicaid beneficiaries with limited education and means to navigate a complicated care delivery and payment system.

Separate from payment and coverage issues, **it is critical that our nation's most vulnerable citizens have access to safe, affordable housing and reliable transportation, which are vital to ensuring access to care and enabling a reasonable chance for recovery**. In our community housing and transportation stand as significant barriers to both physical and behavioral health care. As this constrains patient's compliance with treatment plans and follow-up appointments, it ultimately impedes provider ability to achieve quality outcomes. Non-compliance with treatment complicates each successive intervention with these patients.

B. Expanding Telehealth

As authorization for and acceptance of telehealth services in behavioral health was ramped up throughout the COVID-19 pandemic, the value of such technology for patients, providers and payers was made evident. Telehealth has mitigated barriers to care caused by neighborhood violence, transportation and family care issues and other social determinants of health. It has also allowed providers to better assess patient's living situations, which would not be possible in an office setting.

To help mitigate disparities in access to mental health services, **we urge Congress to work with the Centers for Medicare and Medicaid Services (CMS) to permanently adopt coverage of audio-only services for which the agency covered during the public health emergency.** This is especially important in the neighborhoods served by Temple University Hospital, which will remain entrenched in the opioid epidemic as our nation emerges from the COVID-19 pandemic.

Through its rulemaking authority, CMS prudently applied its rulemaking power by allowing providers to offer certain services via audio-only telehealth technology during the public health emergency. CMS's current position, however, is that it will pay for audio-only mental health services only if the beneficiary receives an in-person visit from the practitioner within six months before the initial audio-only visit and within 12 months of subsequent audio-only visits. As this position only hinders access to mental health services, we urge Congress to work with CMS to reverse this policy.

As we move away from the heightened pandemic allowed approaches, many providers and consumers of behavioral health services fear the telehealth modality will no longer be reimbursed. We urge Congress to unequivocally support this technology that has allowed thousands of additional patients to connect with a provider under extraordinary circumstances.

The value of telehealth service delivery extends far beyond compliance with social distancing measures, disease transmission efforts and access to rural patient populations. Telehealth service delivery, and consumer expectation for such, fits squarely with the technologic evolution that has touched virtually every domain of our society in recent years. The analogy of 'when's the last time someone went into a bank to complete financial transaction?' extends to healthcare consumers' thinking about accessing and receiving care. In today's advanced technological world, there is no rational reason to limit access to needed behavioral health care to an in-person encounter.

C. Increasing Integration, Coordination and Access to Care

Best practices for integrating behavioral health with primary care are those that maximize collaboration and communication. They are designed with a provider team model whereby both physical and behavioral health practitioners share information regularly for the same patient. While the physical co-location of service delivery site is often lauded as a paramount ingredient and key to successful integration, the value of this premise is often overstated. Rather, the finesse of routine and regular communication among the provider team coupled with a shared perspective of treating the entire patient have the greatest impact on integration and health outcomes.

While the strength of the integrated provider team is the driver to successful outcomes, the structure of today's healthcare delivery system regards behavioral and physical health separately. Support and training for providers adopting an integrated care model is necessary. Providers must understand ***how*** to practice differently in the integrated model.

Equally as important is having a sustainable funding models for integrated care. The current reimbursement environment limits the ability to integrate behavioral health services in primary care. The inability to fully fund these services, leaves gaps in behavioral health care management in an already underserved patient population. While pilot projects and grant opportunities to explore the paradigm shift allow for learning, they come with severe limitations that leave providers and health systems struggling to continue the model and make long term strides in re-engineering the healthcare delivery system. **Thus we recommend the development of financing models that incentivize integration of care for consumer's physical health, mental health and substance use disorder needs.**

We also recommend the alignment of *42 CFR Part 2* related to the confidentiality of substance use disorder patient records with the *Health Insurance Portability and Accountability Act*, to reduce the barriers to integrated health care.

D. Strengthening the Behavioral Health Workforce

As we address develop the mental health workforce of the future, we must simultaneously address the mental health and emotional wellness of those on the front line providing care. Thus we applaud the Senate for passing the *Lorna Breen Healthcare Provider Protection Act* (S. 610; HR 1667) and urge its passage in the House. This bill will provide additional training and education to prevent suicide and burnout among healthcare workers.

We also urge Congress to create and financially support more training opportunities for physicians, nurses and other allied health professionals, especially those serving underrepresented and underserved communities, to address current and expected workforce shortages.

Finally, we ask the Congress to support more graduate medical education positions for psychiatric and addiction medicine residencies at hospitals that serve communities with significant behavioral health and substance use disorder challenges.

Thank you for the opportunity to offer our insights and recommendations on these important issues. Should you have any questions, please contact Katherine Levins, Vice President for Public Policy & Government Affairs, at Katherine.Levins@tuhs.temple,edu or 215-707-4851.

Respectfully,

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